

## FINALIZED SEER SINQ'S JULY 2010

**Question: 20100006**

### **Status**

Final

### **Question**

MP/H Rules/Multiple primaries--Kidney, renal pelvis: Would the following be a new primary, if so, what site code would be used? See Discussion.

Original slides were not reviewed and the mass was not described as being metastatic. If you consider the renal fossa soft tissue mass as a new tumor, the MP rules for 'Other Sites' directs you to code it as a new primary based on rule M10 (dx'd more than one year apart). Is this correct or would you consider it a recurrence of the original kidney primary?

### **Discussion**

Pt dx'd with clear cell ca of rt kidney in 2003, treated with nephrectomy. Tumor was limited to kidney. An FNA of the pancreas in 11/07 showed 'changes c/w mets renal cell ca.' In 2009 the pt was found, on CT, to have a mass in the rt renal fossa and an FNA was positive for malignancy. On 8/26/09 an excision of the mass showed 'recurrent renal cell ca, clear cell.' The specimen was labeled as 'soft tissue, rt renal fossa.'

### **Answer**

This is not a new primary. The patient has metastatic disease from the 2003 kidney primary. Clear cell carcinoma metastasized to the pancreas in 2007 and to the right renal fossa in 2009.

### **Last Updated**

07/01/10

**Question: 20100007**

### **Status**

Final

### **Question**

MP/H Rules/Histology--Melanoma: Regarding SINQ #20081044 and Rule H5 and Rule H6 for cutaneous malignant melanoma. What is the difference between the two rules? When would you move on to Rule H6 since you would normally always have a specific cell type.

### **Discussion**

### **Answer**

Rule H6 is used when you do not have a specific cell type other than regressing melanoma, or malignant melanoma, regressing. If you have regressing melanoma with a specific cell type, apply rule H5.

### **Last Updated**

07/01/10

## FINALIZED SEER SING'S JULY 2010

**Question: 20100008**

### **Status**

Final

### **Question**

Primary site--Unknown & ill-defined site: Hospital A says the primary site is bladder, because of their molecular study report. Hospital B says this is an unknown primary. Which is correct? Do we take primary site from these tests, even when no clinical correlation is documented? See Discussion.

### **Discussion**

Patient seen in 2009 at Hospital A for bone pain and found to have metastatic adenocarcinoma. A paraffin block specimen was sent to BioTheragnostics for THEROS CancerTYPE ID Molecular Cancer Classification Tests. The results came back with a 94% likelihood that the urinary bladder was the primary site. No scans were done on the abdomen or pelvis. The patient was sent to Hospital B for radiation to the bones and chemotherapy (Carboplatin and Taxol). The patient died within 6 months.

### **Answer**

Code primary site to bladder in this case. Code the known primary site when given the choice between a known primary site and an unknown primary site.

### **Last Updated**

07/01/10

**Question: 20100009**

### **Status**

Final

### **Question**

MP/H Rules/Multipel primaries--Bladder: A patient has a history of invasive bladder cancer diagnosed several years ago in another state. Now in 2009, he is admitted to your hospital with a positive biopsy for transitional cell carcinoma of the bladder. Is this a new primary (since you do not know the histology of the previous bladder cancer) or can you assume it was urothelial in the past and use rule M6 to consider the 2009 diagnosis as NOT a new primary?

### **Discussion**

### **Answer**

Apply rule M6. The 2009 diagnosis is not a new primary. Transitional cell carcinomas account for more than 90% of bladder cancers. If the patient actually had a small cell, squamous cell, or adenocarcinoma in the past, it would be highly unlikely that no mention was made in the medical record that the patient had one of these rare bladder tumors.

### **Last Updated**

07/15/10

## FINALIZED SEER SINQ'S JULY 2010

**Question: 20100010**

### Status

Final

### Question

MP/H Rules/Multiple primaries--Ovary: Do we abstract as 1 primary or 2 separate primaries because rule M7 says "Bilateral epithelial tumors (8000-8799) of the ovary within 60 days are a single tumor." Does this mean that the tumors in each ovary must be anywhere in this histology range...or must they be the SAME histology AND in the specified range to be one primary? See Discussion.

### Discussion

Patient had bilateral ovarian tumors - right ovary showed serous cystadenocarcinoma and left ovary had clear cell adenocarcinoma. Pathology comment said: Based on the histologic differences of the tumors within each ovary, feel these represent two distinct separate primaries. LN mets are clearly serous ca. Physician staged rt tumor as T2a N1 M0 and left ovary as T1c N0 M0.

### Answer

Apply rule M8 and abstract this case as multiple primaries.

Rule M7 does not apply when each ovary has a distinctly different histology, even when both histologies are within the specified code range. This clarification will be added to the next version of the rules.

### Last Updated

07/01/10

**Question: 20100011**

### Status

Final

### Question

Reportability: Is this benign tumor reportable based on metastasis to a regional lymph node? See Discussion.

### Discussion

"Periampullary duodenum, resection: Gangliocytic paraganglioma, with metastasis to one large periduodenal lymph node. Six other small lymph nodes negative. See comment. Comment: The primary tumor in the duodenum is made up mainly of endocrine cell component. This component appears to have metastasized to a periduodenal lymph node."

### Answer

This neoplasm is reportable because it is malignant as proven by the lymph node metastases. Code the behavior as malignant (/3) when there are lymph node metastases.

### Last Updated

07/01/10

## FINALIZED SEER SINQ'S JULY 2010

**Question: 20100012**

### **Status**

Final

### **Question**

Date of diagnosis--Breast: A mammogram report indicates "suspicious calcifications" without defining what the calcifications are suspicious for, and gives a BIRADS category of 4. A biopsy of the site several days later revealed ductal carcinoma. Should I use the mammogram date or the bx date as the date of diagnosis? See Discussion.

### **Discussion**

The date of diagnosis is the date when cancer was first diagnosed by a recognized medical practitioner, whether clinically or microscopically confirmed. The ambiguous terminology that constitutes the diagnosis is listed in the FORDS, part I, pages 3-4. There are no BIRADS categories listed there, therefore, should not be used by the registrar to determine the earliest date of diagnosis. Also, the term "suspicious for calcification" is not reportable, because calcification is benign condition, unless the physician describes it as malignant. Reference: 46637 12/29/2009 FORDS In the last paragraph is a statement no BIRAD categories listed...cannot be used to determine earliest date of diagnosis. Is this to be followed by the SEER Program?

### **Answer**

The date of diagnosis for this case is the date of the biopsy. There is no reportable diagnosis on the mammogram.

### **Last Updated**

07/01/10

**Question: 20100013**

### **Status**

Final

### **Question**

Reportability--Lymphoma: Should we abstract a case of in situ follicular lymphoma? See Discussion.

### **Discussion**

Patient with mesenteric lymphadenopathy had a biopsy. Consult supports original path findings: The histologic and immunophenotypic findings represent what has been referred to in the literature as "in situ follicular lymphoma." Oncology assessment says: At this point patient has no other obvious evidence of other disease. ...no hepatosplenomegaly...no peripheral adenopathy...no significant abnormalities on PET scan to suggest active lymphoma. No treatment planned at this time, just monitoring. Diagnosis date is in Dec. 2008.

### **Answer**

Do not report in situ lymphoma at this time. Currently, lymphoma cannot be reported with a behavior code of in situ (/2) and it would be incorrect to abstract in situ lymphoma as a /3. We will address the reportability criteria and edits to determine if and how these cases should be reported in the future.

### **Last Updated**

07/15/10

## FINALIZED SEER SINQ'S JULY 2010

Question: 20100014

### Status

Final

### Question

Reportability: Per SINQ 20091021 and 20021151, GIST cases are not reportable unless they are stated to be malignant. A pathologist or clinician must confirm the diagnosis of cancer. We are seeing cases that are not stated to be malignant in the path report nor confirmed as such by a clinician, however, these cases do have information that for other primary sites would typically be taken into consideration when determining reportability. We would like instruction from SEER on how to interpret these cases. See Discussion.

### Discussion

1)The path and final dx only state "GIST". Path indicates that the bulk of the tumor is submucosal. It extends through the muscularis propria and abuts the serosa. Is this reportable? 2)Path and final dx state "GIST". Path report states tumor extends to serosal surface of transverse colon, but not into muscularis propria. CD 117 and CD 34 are positive. Is this reportable? 3)Path and final dx state "GIST". Path indicates that tumor invades through the gastric wall to the serosal surface. Is this reportable? 4)Path and final dx state "GIST". Path indicates that tumor invades pericolic fat tissue. Is this reportable? 5)Path and final dx state "GIST". No further information in path report, however, scans indicate omental caking. Reportable? 6)Path final dx state "GIST". No further information in path report, however, scans indicate hepatic mets. Hepatic mets are not biopsied. Reportable? 7)Bx only performed which states "GIST". Tumor stated to be unresectable and extends into pancreas. Chemo given. Final dx "GIST". Is this reportable? 8)Path and final dx state "GIST". Path states tumor is low to intermediate grade and involves serosal (visceral peritoneum). Reportable? 9)Path and final dx state "GIST". Tumor size is 17.5 cm. Path states "malignant risk". Is this reportable? 10)Path and final dx state "GIST". Path states tumor "into muscularis propria" or tumor "involves muscularis propria" or "infiltrates into muscularis propria". Reportable? 11)Path and final dx state "GIST". Path states "high malignant potential; omentum inv by tumor". It is not stated in path report or final diagnosis to be malignant GIST. Reportable? 12)Path and final dx state "GIST". Path states that tumor arises from wall of small bowel and extends into thin serosal surface. Reportable? 13)Path and final dx state "GIST". Path states minimal invasion of lamina propria; does not penetrate muscularis propria. Reportable? 14)Path and final dx state "GIST". Path states "high mitotic activity >10/50 HPF; high risk for aggressive behavior; moderate malignant potential". Reportable? 15)Path and final dx state "GIST". Path states tumor size is >5 cm. Intermediate risk for aggressive behavior; CD117+ KIT exon 11+. Reportable? 16)Path and final dx state "GIST". Path states "high risk of malignancy". Reportable?

### Answer

For GIST to be reportable, the final diagnosis on the pathology report must definitively state that the GIST is malignant, or invasive, or in situ. Your case number 6 is the only exception, and would be reportable assuming that the scan actually states "hepatic metastases." Based only on the information provided, none of the other examples are reportable. Extension and/or invasion are not sufficient to confirm malignancy. Borderline neoplasms can extend and invade, but do not metastasize. Only malignant neoplasms metastasize.

### Last Updated

07/15/10

Question: 20100015

### Status

Final

### Question

Type of Multiple Tumors/Multiplicity Counter--Breast. Are the data items "Type of Multiple Tumors Reported as One Primary" and "Multiplicity Counter" related? How should they be coded for breast cases in which there are multiple measured invasive tumors, plus DCIS which is not measured nor stated whether it is separate from the invasive tumors? See Discussion.

### Discussion

For example, path report states only "multifocal invasive ductal carcinoma, 1.5 cm and 0.8 cm, and low-grade DCIS." Since the Multiplicity Counter instructions tell us to ignore/do not count foci that are not measured, we interpret this to mean, count only the two invasive foci and ignore the DCIS. Should Type of Multiple Tumors then be coded 30 or 40, since only the invasive tumors were coded in Multiplicity Counter?

### Answer

Code Type of Multiple Tumors 30 [in situ and invasive]. The code in Type of Multiple Tumors may or may not reflect the tumors that were counted in Multiplicity Counter. For this case, it is correct to code 02 in multiplicity counter.

### Last Updated

07/01/10

## FINALIZED SEER SINQ'S JULY 2010

Question: 20100016

### Status

Final

### Question

Primary site/Histology--Brain and CNS: Are intraosseous meningiomas and sphenoid wing meningiomas the same or two different tumors? What is the site/histology for intraosseous meningiomas? See Discussion.

### Discussion

Research states: 1. An intraosseous meningioma is one that grows within a bone. Presumably, in this location meningiomas originate from arachnoid cap cell rests (islands) found in or along vascular channels coursing through the skull (such as diploic or emissary veins or nutrient arteries). Frequently the location for an intraosseous meningioma is in the sphenoorbital region (junction of the sphenoid bone's greater wing - "the temple" region - and the bone constituting the orbital cavity - "eye socket"). 2) The sphenoid bone is a base-of-skull bone which has an inner half known as the medial sphenoid wing, and an outer flared part known as the lateral sphenoid wing. The medial sphenoid wing lies closely approximated to key cranial nerve and vascular ("neurovascular") structures including the optic nerve, internal carotid artery, cavernous sinus, cranial nerves 3-6, and so forth. The lateral sphenoid wing lies closely approximated to the frontal and temporal lobes and their separation known as the Sylvian or lateral fissure. A sphenoid wing WHO grade I meningioma therefore arises from arachnoid cap cells somewhere along the sphenoid wing, and is a benign tumor, although potentially troublesome depending on its size and its effect upon surrounding brain neurovascular structures.

### Answer

Neither intraosseous nor sphenoid wing meningiomas are reportable at this time. These are meningiomas of the bone. Benign brain and CNS tumors must meet both site and histology criteria to be reportable. These tumors meet the histology criteria, but do not meet the site criteria -- bone is not a reportable site for benign brain and CNS tumors.

### Last Updated

07/15/10

Question: 20100017

### Status

Final

### Question

MP/H Rules/Multiple primaries--Prostate: This is a MP/H question for an unusual prostate case. See Discussion.

There is no information of a history of a squamous carcinoma in the urinary system that could have involved the prostatic urethra so, the MPH rules would make this a second primary with the histology of 8560/3 adenosquamous carcinoma. Is this correct?

### Discussion

History: Patient was diagnosed many years ago with adenocarcinoma of the prostate and treated with hormonal and radiation therapy. The patient recently underwent a TURP and now is found to have adenosquamous carcinoma of the prostate. The Pathology comment states squamous carcinoma of the prostate is rare and is often associated with a history of hormonal or radiation therapy.

### Answer

Based on the limited information available for this unusual case, abstract a second prostate primary and code the histology as adenosquamous carcinoma. Rule M3 does not apply in this case. Apply rule M10.

### Last Updated

07/15/10

## FINALIZED SEER SINQ'S JULY 2010

### Question: 20100018

#### Status

Final

#### Question

Reportability--Hematopoietic, NOS: Is this case reportable? See Discussion.

#### Discussion

A patient was diagnosed with light chain disease based on SPEP and urine testing.(2010 case) Bone marrow aspiration and biopsy were done. Flow cytometry, cytogenetic studies and FISH for plasma cell disorders are all normal. Medical Oncologist states diagnosis as light chain disease. Patient was started on Revlimid, dexamethasone and Velcade.

I reviewed the case reportability instructions and felt this fell under Instruction 1, note 1. Immunoglobulin deposition disease (preferred term for light chain disease) codes out to a 9769/1. This is normally a nonreportable diagnosis but if I am interpreting the instructions right, I would abstract this case using the above morphology code and Primary site of bone marrow. Would this be correct?

#### Answer

This case is not reportable.

Light chains are produced in neoplastic plasma cells (multiple myeloma) and are called Bence-Jones proteins. That is why your physician did the cytogenetic studies and FISH to rule out plasma cell disease. 50-60% of people with Light-chain deposition disease (LCDD) have an associated lymphoproliferative disorder, most commonly multiple myeloma. The remaining patients develop LCDD in the setting of progression of monoclonal gammopathy of unknown significance (MGUS) with no evidence of neoplastic plasma cell proliferation. Your patient falls in this category, MGUS, which is not reportable.

#### Last Updated

07/01/10

### Question: 20100019

#### Status

Final

#### Question

Histology--Ovary: What is the histology code for this case? At surgery a 25 cm left ovarian mass is found adherent to the anterior abdominal wall. Pathology reads: Mucinous neoplasm (26 cm) of low malignant potential (borderline mucinous cystadenoma) with extensive intraepithelial ca and focal microinvasion. Right ovary, fallopian tubes, uterus, omentum, biopsies of diaphragm, 28 para-aortic and pelvic LNS and peritoneal fluid are all negative for malignancy.

#### Discussion

#### Answer

Histology code 8470/3 [mucinous cystadenocarcinoma] is the best choice in this case. There is a mucinous cystadenoma (8470/0) with intraepithelial carcinoma and focal microinvasion. 8470/3 comes as close as possible to the description of the tumor.

#### Last Updated

07/30/10

## FINALIZED SEER SINC'S JULY 2010

**Question: 20100020**

**Status**

Final

**Question**

Histology--Brain and CNS: What is the correct histology and behavior code for Cystic Glioma?

**Discussion**

**Answer**

Code the histology 9380/3 [Malignant glioma; Glioma, NOS]. There is no specific code for cystic glioma.

**Last Updated**

07/29/10

**Question: 20100022**

**Status**

Final

**Question**

Multiple primaries/Histology--Heme & Lymphoid Neoplasms: Is follicular B cell lymphoma followed by anaplastic T cell lymphoma a new primary? If so, what is the histology code? See Discussion.

**Discussion**

Our patient has follicular B cell lymphoma, grade 1, diagnosed in 2008. He was stage 4 and was treated with adriamycin, cytoxan, rituxan, and prednisone. In 2010, he is back in the hospital with what his medical oncologist calls progression/recurrence of his lymphoma with pathology that has changed to anaplastic T cell lymphoma. There was immunophenotyping but no more specific diagnosis. The patient died within 3 months.

**Answer**

Abstract the anaplastic T cell lymphoma as a new primary. Code the histology 9714/3 [Anaplastic large cell lymphoma, ALK-positive].

Multiple primaries: Rule M13 applies. The multiple primaries calculator result for 9695 and 9714 is "New Primary."

Histology: Rule PH40 applies. Search the heme database for "anaplastic." The only T cell anaplastic lymphoma is Anaplastic large cell lymphoma, ALK-positive [9714].

**Last Updated**

07/29/10

## FINALIZED SEER SINQ'S JULY 2010

### Question: 20100025

#### Status

Final

#### Question

MP/H Rules/Primary site: See discussion. Is primary site changed to C689? Is C689 only coded if more than one primary site is involved at diagnosis? Not clear. Involves use of M8 as logic as one primary.

#### Discussion

Renal pelvis, Code Primary Site C659, # tumors 01 Dx 1/23/08. 1/29/08 Kidney & ureter right radical nephrectomy: Invasive grade 3 of 3 papillary urothelial cell carcinoma arising in the depth of a calyx in mid portion of kidney. 06/01/2009 TURBT: 3 separate lesions on the right side of the bladder 06/01/2009 Right lateral bladder tumor: high grade urothelial carcinoma in-situ. 3 tumors, largest being 7mm Using M8 one primary.

#### Answer

Rule M8 applies. This is a single primary. The primary site was coded to C659 in 2008. Do not change the primary site code.

#### Last Updated

07/29/10

### Question: 20100026

#### Status

Final

#### Question

Multiplicity Counter: How should multiplicity counter be coded for this case? See discussion. Are tumors added even if insitu?

#### Discussion

Renal pelvis, Code Primary Site C659, # tumors 01 Dx 1/23/08. 1/29/08 kidney & ureter right radical nephrectomy: Invasive grade 3 of 3 papillary urothelial carcinoma arising in the depth of a calyx in mid portion of kidney. 06/01/2009 TURBT: 3 separate lesions on the right side of the bladder 06/01/2009 Right lateral bladder tumor: high grade urothelial carcinoma in-situ. 3 tumors, largest being 7mm 02/08/10 TURBT 1 lesion left side of bladder - 02/08/10 high grade urothelial carcinoma in-situ. 1 tumor 4mm. Using M8 one primary. Do not add tumor to multiplicity counter, change count only once; is this correct?

#### Answer

Code multiplicity counter 04. Count both invasive and in situ tumors.

Multiplicity counter would have been coded 01 in 2008. Add the three in situ tumors diagnosed in 2009 to the first tumor and update multiplicity counter to 04. Make only one update to multiplicity counter. Since multiplicity counter has already been updated once, the fifth tumor diagnosed in 2010 does not need to be added.

#### Last Updated

07/29/10